FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040535

Facility Name: HARMONY NURSING AND REHAB

Address: 3919 WEST FOSTER (Number) CHICAGO (City) 60625 (Zip Code)

County: COOK

Telephone Number: (773) 588-9500 **Fax #** (773) 588-9533

IDPA ID Number: 363969873001

Date of Initial License for Current Owners: 12/14/94

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) NOSHIR R. DARUWALLA, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax# (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3	60	Intermediate (ICF)	60	21,900	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	180	TOTALS	180	65,700	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	35,403	9,108	4,388	48,899	8
9	SNF/PED					9
10	ICF	8,611	5,525		14,136	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	44,014	14,633	4,388	63,035	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.94%

D. How many bed-hold days during this year were paid by Public Aid?
997 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/14/94

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/25/94 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 39 and days of care provided 4320

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	305,754	69,140	5,980	380,874		380,874	2,997	383,871			1
2	Food Purchase		309,502		309,502	(53,801)	255,701	(850)	254,851			2
3	Housekeeping	323,316	41,963		365,279		365,279	9,218	374,497			3
4	Laundry	71,238	40,604		111,842		111,842		111,842			4
5	Heat and Other Utilities			167,383	167,383		167,383	2,708	170,091			5
6	Maintenance	66,586	15,520	85,470	167,576		167,576	(5,193)	162,383			6
7	Other (specify):*											7
8	**TOTAL General Services**	766,894	476,729	258,833	1,502,456	(53,801)	1,448,655	8,880	1,457,535			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	2,129,663	133,265	30,552	2,293,480		2,293,480		2,293,480			10
10a	Therapy	228,643			228,643		228,643		228,643			10a
11	Activities	94,522	11,020	2,256	107,798		107,798		107,798			11
12	Social Services	145,214		3,893	149,107		149,107		149,107			12
13	Nurse Aide Training											13
14	Program Transportation			400	400		400		400			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,598,042	144,285	55,101	2,797,428		2,797,428		2,797,428			16
	C. General Administration											
17	Administrative	116,504		233,000	349,504		349,504	36,934	386,438			17
18	Directors Fees											18
19	Professional Services			507,210	507,210		507,210	(375,326)	131,884			19
20	Dues, Fees, Subscriptions & Promotions			75,224	75,224		75,224	(51,429)	23,795			20
21	Clerical & General Office Expenses	184,469	3,472	211,952	399,893		399,893	4,404	404,297			21
22	Employee Benefits & Payroll Taxes			627,394	627,394	53,801	681,195		681,195			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,277	5,277		5,277	1,596	6,873			24
25	Other Admin. Staff Transportation			36	36		36		36			25
26	Insurance-Prop.Liab.Malpractice			139,779	139,779		139,779	(2,239)	137,540			26
27	Other (specify):*							40,265	40,265			27
28	**TOTAL General Administration**	300,973	3,472	1,799,872	2,104,317	53,801	2,158,118	(345,795)	1,812,323			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,665,909	624,486	2,113,806	6,404,201		6,404,201	(336,915)	6,067,286			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number HARMONY NURSING AND REHAB #0040535 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			46,323	46,323		46,323	435,185	481,508			30
31	Amortization of Pre-Op. & Org.							10,944	10,944			31
32	Interest			178,568	178,568		178,568	616,161	794,729			32
33	Real Estate Taxes							444,316	444,316			33
34	Rent-Facility & Grounds			1,348,560	1,348,560		1,348,560	(1,348,560)				34
35	Rent-Equipment & Vehicles			30,550	30,550		30,550	(9,142)	21,408			35
36	Other (specify):*							45,377	45,377			36
37	**TOTAL Ownership**			1,604,001	1,604,001		1,604,001	194,281	1,798,282			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	176,955	178,496		355,451		355,451	(18,917)	336,534			39
40	Barber and Beauty Shops			15,438	15,438		15,438		15,438			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			98,550	98,550		98,550		98,550			42
43	Other (specify):*	43,561			43,561		43,561	(43,561)				43
44	**TOTAL Special Cost Centers**	220,516	178,496	113,988	513,000		513,000	(62,478)	450,522			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,886,425	802,982	3,831,795	8,521,202		8,521,202	(205,112)	8,316,090			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(135)	02		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	238,102	30		9
10	Interest and Other Investment Income	(11,910)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(715)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,049)	21		18
19	Entertainment				19
20	Contributions	(35,569)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(104,916)	21		24
25	Fund Raising, Advertising and Promotional	(27,499)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(15,000)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(106,679)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (65,370)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(139,742)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (139,742)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (205,112)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

HARMONY NURSING AND REHAB

ID# 0040535

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-Allowable Auto Leases	$ (10,884)	35	1
2	Copy Income	(20)	21	2
3	PY Therapy Settlement	(18,917)	39	3
4	Marketing Salary	(43,561)	43	4
5	Keiro Building - Franchise Tax	(200)	21	5
6	Keiro Building - Accounting	(6,681)	19	6
7	Keiro Building - Trust Fees	(900)	21	7
8	Non-Allowable Auto Lease Insurance	(2,753)	26	8
9	Capitalized Repairs & Maintenance	(7,859)	06	9
10	Non-Allowable Legal - Retainer Fees	(12,275)	19	10
11	Non-Allowable Legal	(2,629)	19	11
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STATE OF ILLINOIS

Summary A

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			2,997									2,997	1
2	Food Purchase	(850)											(850)	2
3	Housekeeping			9,218									9,218	3
4	Laundry													4
5	Heat and Other Utilities			2,708									2,708	5
6	Maintenance	(7,859)		2,666									(5,193)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(8,709)		17,589									8,880	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**													16
	C. General Administration													
17	Administrative				36,934								36,934	17
18	Directors Fees													18
19	Professional Services	(21,585)	6,681	(295,886)	(64,536)								(375,326)	19
20	Fees, Subscriptions & Promotions	(63,068)		1,152	10,487								(51,429)	20
21	Clerical & General Office Expenses	(122,085)	1,100	122,120	3,269								4,404	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,558	38								1,596	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice	(2,753)		514									(2,239)	26
27	Other (specify):*			33,788	6,477								40,265	27
28	**TOTAL General Administration**	(209,491)	7,781	(136,754)	(7,331)								(345,795)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(218,200)	7,781	(119,165)	(7,331)								(336,915)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	238,102	181,548	15,535									435,185	30
31	Amortization of Pre-Op. & Org.		10,779	165									10,944	31
32	Interest	(11,910)	604,378	23,693									616,161	32
33	Real Estate Taxes		438,982	5,334									444,316	33
34	Rent-Facility & Grounds		(1,348,560)										(1,348,560)	34
35	Rent-Equipment & Vehicles	(10,884)		1,742									(9,142)	35
36	Other (specify):*		45,377										45,377	36
37	**TOTAL Ownership**	215,308	(67,496)	46,469									194,281	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(18,917)											(18,917)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(43,561)											(43,561)	43
44	**TOTAL Special Cost Centers**	(62,478)											(62,478)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(65,370)	(59,715)	(72,696)	(7,331)								(205,112)	45

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 1,348,560	Keiro Building Partnership	100.00%	$	$ (1,348,560)	1
2	V	32	Interest Income	64,956	Keiro Building Partnership	100.00%		(64,956)	2
3	V	21	Franchise Tax		Keiro Building Partnership	100.00%	200	200	3
4	V	36	MIP Insurance		Keiro Building Partnership	100.00%	45,377	45,377	4
5	V	19	Accounting		Keiro Building Partnership	100.00%	6,681	6,681	5
6	V	21	Trust Fees		Keiro Building Partnership	100.00%	900	900	6
7	V	32	Mortgage Interest		Keiro Building Partnership	100.00%	669,334	669,334	7
8	V	33	Real Estate Taxes		Keiro Building Partnership	100.00%	438,982	438,982	8
9	V	30	Depreciation		Keiro Building Partnership	100.00%	181,548	181,548	9
10	V	31	Amortization - Loan Costs		Keiro Building Partnership	100.00%	10,779	10,779	10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,413,516			$ 1,353,801	$ * (59,715)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	DIETARY	$	ITEX COMPANY / A.K. CARE	100.00%	$ 2,997	$ 2,997	15
16	V	03	HOUSEKEEPING		ITEX COMPANY / A.K. CARE	100.00%	9,218	9,218	16
17	V	05	UTILITIES		ITEX COMPANY / A.K. CARE	100.00%	2,708	2,708	17
18	V	06	REPAIRS AND MAINT.		ITEX COMPANY / A.K. CARE	100.00%	2,666	2,666	18
19	V	19	PROFESSIONAL FEES		ITEX COMPANY / A.K. CARE	100.00%	5,931	5,931	19
20	V	20	FEES, SUBSCRIPTIONS		ITEX COMPANY / A.K. CARE	100.00%	1,152	1,152	20
21	V	21	CLERICAL AND GENERAL		ITEX COMPANY / A.K. CARE	100.00%	18,837	18,837	21
22	V	24	EDUCATION/SEMINARS		ITEX COMPANY / A.K. CARE	100.00%	1,558	1,558	22
23	V	26	INSURANCE		ITEX COMPANY / A.K. CARE	100.00%	514	514	23
24	V	27	EMPLOYEE BENEFITS		ITEX COMPANY / A.K. CARE	100.00%	1,007	1,007	24
25	V	30	DEPRECIATION		ITEX COMPANY / A.K. CARE	100.00%	15,535	15,535	25
26	V	31	AMORTIZATION		ITEX COMPANY / A.K. CARE	100.00%	165	165	26
27	V	32	INTEREST		ITEX COMPANY / A.K. CARE	100.00%	23,693	23,693	27
28	V	33	REAL ESTATE TAXES		ITEX COMPANY / A.K. CARE	100.00%	5,334	5,334	28
29	V	35	EQUIPMENT RENTAL		ITEX COMPANY / A.K. CARE	100.00%	1,742	1,742	29
30	V								30
31	V								31
32	V	21	CLERICAL SALARIES		ITEX COMPANY / A.K. CARE	100.00%	103,283	103,283	32
33	V	27	GEN ADMIN. - EMP. BEN.		ITEX COMPANY / A.K. CARE	100.00%	32,781	32,781	33
34	V								34
35	V	19	HOME OFFICE FEES	301,817	ITEX COMPANY / A.K. CARE	100.00%		(301,817)	35
36	V								36
37	V								37
38	V								38
39	Total			$ 301,817			$ 229,121	$ * (72,696)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	$	CAREPATH HEALTH NETWORK	100.00%	$ 36,934	$ 36,934	15
16	V	19	PROFESSIONAL FEES		CAREPATH HEALTH NETWORK	100.00%	1,296	1,296	16
17	V	20	FEES, SUBSCRIPTIONS		CAREPATH HEALTH NETWORK	100.00%	10,487	10,487	17
18	V	21	CLERICAL AND GENERAL		CAREPATH HEALTH NETWORK	100.00%	3,269	3,269	18
19	V	24	SEMINARS		CAREPATH HEALTH NETWORK	100.00%	38	38	19
20	V	27	GEN ADMIN.- EMP. BEN.		CAREPATH HEALTH NETWORK	100.00%	6,477	6,477	20
21	V								21
22	V								22
23	V								23
24	V	19	HOME OFFICE FEES	65,832	CAREPATH HEALTH NETWORK	100.00%		(65,832)	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 65,832			$ 58,501	$ * (7,331)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bernard Hollander	Owner	Administrative	28.67%	See Attached	2	3.08%		$		1
2	Mark Hollander	Owner	Administrative	9.56%	See Attached	30	50.00%	Mgmt Fees	233,000	17 - 03	2
3	Jack Rajchenbach	Owner	Administrative	28.67%	See Attached	2	3.08%				3
4	Robert Hartman	Owner	Administrative	28.67%	See Attached	3.57	5.49%				4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 233,000		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: ITEX COMPANY
Street Address: 6633 N. LINCOLN AVE.
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 679-9141
Fax Number: (847) 679-1820

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	DIETARY	AVAIL. BED DAYS	462,455	5	$ 21,096	$	65,700	$ 2,997	1
2	03	HOUSEKEEPING	AVAIL. BED DAYS	462,455	5	64,883		65,700	9,218	2
3	05	UTILITIES	AVAIL. BED DAYS	462,455	5	19,061		65,700	2,708	3
4	06	REPAIRS AND MAINT.	AVAIL. BED DAYS	462,455	5	18,769		65,700	2,666	4
5	19	PROFESSIONAL FEES	AVAIL. BED DAYS	462,455	5	41,751		65,700	5,931	5
6	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	462,455	5	8,107		65,700	1,152	6
7	21	CLERICAL AND GENERAL	AVAIL. BED DAYS	462,455	5	132,593		65,700	18,837	7
8	24	EDUCATION/SEMINARS	AVAIL. BED DAYS	462,455	5	10,970		65,700	1,558	8
9	26	INSURANCE	AVAIL. BED DAYS	462,455	5	3,618		65,700	514	9
10	27	EMPLOYEE BENEFITS	AVAIL. BED DAYS	462,455	5	7,090		65,700	1,007	10
11	30	DEPRECIATION	AVAIL. BED DAYS	462,455	5	109,347		65,700	15,535	11
12	31	AMORTIZATION	AVAIL. BED DAYS	462,455	5	1,165		65,700	165	12
13	32	INTEREST	AVAIL. BED DAYS	462,455	5	166,773		65,700	23,693	13
14	33	REAL ESTATE TAXES	AVAIL. BED DAYS	462,455	5	37,542		65,700	5,334	14
15	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	462,455	5	12,263		65,700	1,742	15
16										16
17										17
18	21	CLERICAL SALARIES	DIRECT ALLOC.		5	708,007	708,007		103,283	18
19	27	GEN ADMIN. - EMP. BEN.	DIRECT ALLOC.		5	224,712			32,781	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,587,747	$ 708,007		$ 229,121	25

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CAREPATH HEALTH NETWORK
Street Address: 6633 N LINCOLN AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (888) 707-6700
Fax Number: (847) 679-2150

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	CARE PATH FEES	629,760	13	$ 353,316	$ 353,316	65,832	$ 36,934	1
2	19	PROFESSIONAL FEES	CARE PATH FEES	629,760	13	12,396		65,832	1,296	2
3	20	FEES, SUBSCRIPTIONS	CARE PATH FEES	629,760	13	100,317		65,832	10,487	3
4	21	CLERICAL AND GENERAL	CARE PATH FEES	629,760	13	31,275		65,832	3,269	4
5	24	SEMINARS	CARE PATH FEES	629,760	13	366		65,832	38	5
6	27	GEN ADMIN.- EMP. BEN.	CARE PATH FEES	629,760	13	61,960		65,832	6,477	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 559,630	$ 353,316		$ 58,501	25

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Hill-Rom		X	Medical Equipment	$593	03/15/00	$ 12,856	$ 1,172	02/15/02	10.00%	$ 482	1
2	Cambridge		X	Mortgage	$61,990	10/01/97	9,317,100	9,041,304	10/01/32	7.38%	669,334	2
3												3
4												4
5												5
	Working Capital											
6	American National Bank		X	Working Capital			2,000,000	2,000,000		4.75%	50,958	6
7	American National Bank		X	Working Capital			1,200,000			4.75%	792	7
8	American National Bank		X	Working Capital			1,900,000				68,331	8
9	TOTAL Facility Related				$62,583		$ 14,429,956	$ 11,042,476			$ 789,897	9
	B. Non-Facility Related*											
10	See Supplemental Schedule							161,510			16,313	10
11	Insurance Financing		X								429	11
12	Interest Income										(11,910)	12
13												13
14	TOTAL Non-Facility Related						$	$ 161,510			$ 4,832	14
15	TOTALS (line 9+line14)						$ 14,429,956	$ 11,203,986			$ 794,729	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Keiro Building Partnership	X		InterCompany Exchange			$	$ 0		6.00%	$ 57,576	1
2	Itex Management Company	X		InterCompany Exchange				2,260		0.00%	0	2
3	Glenview Terrace	X		InterCompany Exchange				157,114		0.00%	0	3
4	NuVision	X		InterCompany Exchange				2,136		0.00%	0	4
5	Interest Income - Keiro	X									(64,956)	5
6	Alloc. - Itex Mgmt. / A.K. Care	X									23,693	6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$ 161,510			$ 16,313	21

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	338,022	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	384,361	2
3. Under or (over) accrual (line 2 minus line 1).	$	46,339	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	397,977	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	444,316	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	256,331	8
	1997	318,447	9
	1998	324,101	10
	1999	321,925	11
	2000	379,027	12

Real Estate Tax Accrual = $379,027 * 1.05 = $397,977

Allocated R.E. Tax Expense = $5,334

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME HARMONY NURSING AND REHAB COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0040535

CONTACT PERSON REGARDING THIS REPORT STEVE LAVENDA

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-11-300-007-0000	Nursing Home	$ 379,026.15	$ 379,026.15
2.	10-35-329-014-0000	Central Office	$ 39,270.15	$ 5,333.55
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 418,296.30	$ 384,359.70

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 64,216 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories Four

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 377,250
2. Number of Years Over Which it is Being Amortized: 35
3. Current Period Amortization: 10,944
4. Dates Incurred: 1997

Nature of Costs: Keiro Building LLC = $10,779, Allocation from Item Mgmt. / A.K. Care = $165
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1994	$ 600,000	1
2					2
3	TOTALS			$ 600,000	3

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1994	11,156		20	621	621	4,313	9
10	Various			1996	9,553		20	477	477	2,761	10
11	Various			1997	8,612		20	431	431	2,060	11
12								-		-	12
13								-		-	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		7,318,806	187,179		361,057	173,878	2,546,292	68
69	Financial Statement Depreciation			2,667			(2,667)		69
70	TOTAL (lines 4 thru 69)		$ 7,348,127	$ 189,846		$ 362,586	$ 172,740	$ 2,555,426	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 7,348,127	$ 189,846		$ 362,586	$ 172,740	$ 2,555,426	1
2	ELEVATOR	1998	1,360		20	68	68	266	2
3	30 AMP-208 VOLT CIRC	1998	1,000		20	50	50	183	3
4	WALLPAPER	1998	1,923		20	96	96	376	4
5	DECORATING-PAINTING	1998	2,650		20	133	133	510	5
6	WINDOWS	1998	546		20	27	27	86	6
7	INGITER/CABLE	1998	620		20	31	31	98	7
8	LOCKSET	1998	660		20	33	33	102	8
9	FIRE DAMPERS	1998	1,089		20	54	54	167	9
10	SMOKE DETECTOR	1998	590		20	30	30	100	10
11	RECIRCULATING PUMPS	1998	1,580		20	79	79	270	11
12	PLUMBING	1998	893		20	45	45	169	12
13	CHAIN LINK FENCE	1999	1,879		20	94	94	274	13
14	FIRE DAMPERS	1999	8,775		20	439	439	1,244	14
15	FIRE DAMPERS	1999	2,200		20	110	110	303	15
16	FENCE	1999	1,389		20	69	69	184	16
17	OUTSIDE HYDRANTS	1999	2,455		20	123	123	308	17
18	TRANSFER SWITCHES	1999	37,000		20	1,850	1,850	5,088	18
19	DOORS	1999	1,947		20	97	97	283	19
20	VINYL	1999	522		20	26	26	67	20
21	WATER HEATER-16 GAL.	1999	129		20	6	6	14	21
22	DOOR CLOSER	1999	630		20	32	32	93	22
23	FIRE ALARM RELAY BOA	1999	1,130		20	57	57	128	23
24	AIR CONDITIONER	1999	1,104		20	55	55	138	24
25	AIR CONDITIONER	1999	2,208		20	110	110	266	25
26	EMERGENCY SYSTEM	2000	19,300		20	965	965	1,367	26
27	DOORLOCK SAFETY	2000	1,174		20	59	59	59	27
28	WATER BOILER	2000	1,486		20	74	74	74	28
29	WALLPAPER VINYL	2000	904		20	45	45	45	29
30	WINDOW SYSTEM	2000	647		20	32	32	32	30
31	LIGHTING	2000	1,174		20	59	59	59	31
32	WOODEN HOOK-UP	2000	1,737		20	87	87	87	32
33	BOILER DAMPER	2000	3,405		20	170	170	170	33
34	TOTAL (lines 1 thru 33)		$ 7,452,233	$ 189,846		$ 367,791	$ 177,945	$ 2,568,036	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 7,452,233	$ 189,846		$ 367,791	$ 177,945	$ 2,568,036	1
2	DSL CABLE WIRE	2000	1,035		20	52	52	52	2
3	RADIATOR	2000	2,001		20	100	100	100	3
4	THERMOSTAT	2000	2,548		20	127	127	127	4
5	COMMUNICATION	2000	1,260		20	63	63	63	5
6	SMOKE DETECTOR	2001	645		20	30	30	30	6
7	SINGLE & DUAL JACK	2001	581		20	17	17	17	7
8	FIRE EQUIPMENT	2001	1,695		20	36	36	36	8
9	FOX VALLEY HEATING	2001	11,600		20	193	193	193	9
10	LOCKS	2001	559		20	9	9	9	10
11	LOCKS	2001	559		20	2	2	2	11
12	AC REPAIRS	2001	1,231		20	26	26	26	12
13	DOOR	2001	613		20	8	8	8	13
14	PARKING LOT SEALCOAT	2001	3,500		20	58	58	58	14
15	COOLER - LOCK BAR	2001	789		20	3	3	3	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,480,849	$ 189,846		$ 368,515	$ 178,669	$ 2,568,760	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 7,480,849	$ 189,846		$ 368,515	$ 178,669	$ 2,568,760	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,480,849	$ 189,846		$ 368,515	$ 178,669	$ 2,568,760	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 7,480,849	$ 189,846		$ 368,515	$ 178,669	$ 2,568,760	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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19									19
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,480,849	$ 189,846		$ 368,515	$ 178,669	$ 2,568,760	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 7,480,849	$ 189,846		$ 368,515	$ 178,669	$ 2,568,760	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,480,849	$ 189,846		$ 368,515	$ 178,669	$ 2,568,760	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 7,480,849	$ 189,846		$ 368,515	$ 178,669	$ 2,568,760	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,480,849	$ 189,846		$ 368,515	$ 178,669	$ 2,568,760	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 7,480,849	$ 189,846		$ 368,515	$ 178,669	$ 2,568,760	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,480,849	$ 189,846		$ 368,515	$ 178,669	$ 2,568,760	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 7,480,849	$ 189,846		$ 368,515	$ 178,669	$ 2,568,760	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,480,849	$ 189,846		$ 368,515	$ 178,669	$ 2,568,760	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1994		$ 7,019,409	$ 179,985	20	$ 350,971	$ 170,986	$ 2,463,902	4
5			1993		227,884	5,843	35	6,511	668	55,885	5
6											6
7											7
8											8
	Improvement Type**										
9	Allocation - Keiro Building LLC			1995	19,743	87	20	987	900	6,488	9
10	Allocation - Itex Mgmt.			1993	28,674	346	20	1,434	1,088	12,482	10
11	Allocation - Itex Mgmt.			1994	15,402	561	20	770	209	5,607	11
12	Allocation - Itex Mgmt.			1995	2,625	217	20	131	86	813	12
13	Allocation - Itex Mgmt.			1996	149	13	20	7	(6)	45	13
14	Allocation - Itex Mgmt.			1997	4,428	114	20	221	107	996	14
15	Allocation - Itex Mgmt.			1999	492	13	20	25	12	74	15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
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58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 7,318,806	$ 187,179		$ 361,057	$ 174,050	$ 2,546,292	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,116,817	$ 32,107	$ 111,590	$ 79,483	10	$ 757,602	71
72	Current Year Purchases	21,703	21,453	1,403	(20,050)	10	1,403	72
73	Fully Depreciated Assets	10,876				10	10,876	73
74								74
75	TOTALS	$ 1,149,396	$ 53,560	$ 112,993	$ 59,433		$ 769,881	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 9,230,245	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 243,406	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 481,508	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 238,102	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,338,641	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 11,207 Description: Pitney Bowes (Postage Meter) = $2,123, Canon Financial (Copier Machine) - $7,342, Itex = $1,742
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	Oldsmobile	$ 529	$ 1,339	17
18	Facility	Jaguar	1,125	10,201	18
19	Facility	Infiniti	1,331	9,545	19
20	Non-Allowable Lease	Pg. 5 Adjustments		(10,884)	20
21	TOTAL		$ 2,985	$ 10,201	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 01	hrs	$ 64,452		$	$		$ 64,452	1
2	Licensed Speech and Language Development Therapist	39 - 01	hrs	315					315	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	112,188					112,188	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				130,019		130,019	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):						48,477		48,477	13
14	TOTAL			$ 176,955		$	$ 178,496		$ 355,451	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 55,061	$ 397,534	1
2	Cash-Patient Deposits	89,644	89,644	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,607,440	1,607,440	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	131,497	169,046	6
7	Other Prepaid Expenses	310,726	310,726	7
8	Accounts Receivable (owners or related parties)	788,197	557,642	8
9	Other(specify): See supplemental schedule	198,521	763,507	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,181,086	$ 3,895,539	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		600,000	13
14	Buildings, at Historical Cost		7,019,409	14
15	Leasehold Improvements, at Historical Cost	104,518	107,918	15
16	Equipment, at Historical Cost	181,763	1,105,246	16
17	Accumulated Depreciation (book methods)	(158,895)	(2,348,831)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		377,250	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(45,809)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 127,386	$ 6,815,183	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,308,472	$ 10,710,722	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 260,008	$ 323,074	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	66,341	66,341	28
29	Short-Term Notes Payable	3,362,683	2,162,683	29
30	Accrued Salaries Payable	110,788	110,788	30
31	Accrued Taxes Payable (excluding real estate taxes)	27,849	27,849	31
32	Accrued Real Estate Taxes(Sch.IX-B)		397,977	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	45,404	45,404	35
	Other Current Liabilities(specify):			
36	See supplemental schedule	66,804	66,804	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,939,877	$ 3,200,920	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		9,041,303	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 9,041,303	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,939,877	$ 12,242,223	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (631,405)	$ (1,531,501)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,308,472	$ 10,710,722	48

*(See instructions.)

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (649,938)	1	
2	Restatements (describe):		2	
3	Change in PY Stockholder Distribution	216,000	3	
4	PY State Replacement Tax	(6,910)	4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (440,848)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	439,443	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(630,000)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (190,557)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (631,405)	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,336,432	1
2	Discounts and Allowances for all Levels	(521,934)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,814,498	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	590,741	6
7	Oxygen	5,915	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 596,656	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	16,250	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	7,843	15
16	Rental of Facility Space		16
17	Sale of Drugs	185,395	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	86,792	19
20	Radiology and X-Ray		20
21	Other Medical Services	91,981	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 388,261	23
	D. Non-Operating Revenue		
24	Contributions	500	24
25	Interest and Other Investment Income***	11,910	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 12,410	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	148,820	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 148,820	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,960,645	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,502,456	31
32	Health Care	2,797,428	32
33	General Administration	2,104,317	33
	B. Capital Expense		
34	Ownership	1,604,001	34
	C. Ancillary Expense		
35	Special Cost Centers	414,450	35
36	Provider Participation Fee	98,550	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,521,202	40
41	**Income before Income Taxes (line 30 minus line 40)****	439,443	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 439,443	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,887	2,155	$ 65,831	$ 30.55	1
2	Assistant Director of Nursing	1,918	2,186	56,302	25.76	2
3	Registered Nurses	36,032	45,373	831,663	18.33	3
4	Licensed Practical Nurses	7,699	9,175	150,422	16.39	4
5	Nurse Aides & Orderlies	95,091	108,040	890,168	8.24	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	5,682	5,991	176,955	29.54	7
8	Rehab/Therapy Aides	15,260	19,458	228,643	11.75	8
9	Activity Director	1,643	1,683	24,048	14.29	9
10	Activity Assistants	8,295	8,896	70,474	7.92	10
11	Social Service Workers	12,079	12,788	145,214	11.36	11
12	Dietician					12
13	Food Service Supervisor	3,405	3,647	54,337	14.90	13
14	Head Cook	4,574	5,191	49,460	9.53	14
15	Cook Helpers/Assistants	28,243	30,316	201,957	6.66	15
16	Dishwashers					16
17	Maintenance Workers	6,061	6,321	66,586	10.53	17
18	Housekeepers	39,908	42,545	323,316	7.60	18
19	Laundry	9,463	10,125	71,238	7.04	19
20	Administrator	1,837	2,333	116,504	49.94	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,757	16,835	184,469	10.96	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	10,593	12,829	135,277	10.54	31
32	Other Health Care(specify)					32
33	Other(specify)	1,546	2,049	43,561	21.26	33
34	TOTAL (lines 1 - 33)	306,973	347,936	$ 3,886,425 *	$ 11.17	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 5,980	01-03	35
36	Medical Director	Monthly	18,000	09-03	36
37	Medical Records Consultant	Monthly	4,752	10-03	37
38	Nurse Consultant	Monthly	24,000	10-03	38
39	Pharmacist Consultant	Monthly	1,800	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	2,256	11-03	44
45	Social Service Consultant	78	3,893	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	78	$ 60,681		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
John Marc Sianghio	Administrator	0	$ 116,504
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 116,504

B. Administrative - Other

Description	Amount
Mark Hollander - Management Fees	$ 233,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 233,000

C. Professional Services

Vendor/Payee	Type	Amount
A.K. Care	Bookkeeping / Data Proc.	$ 301,817
CarePath	Bookkeeping	65,832
Susan Fox	Accounting	14,940
Frost, Ruttenberg & Rothblatt	Accounting	55,157
Commitment Consulting	Accounting	4,241
Power Software	Data Processing	11,221
Health Management	Data Processing	378
Medi.com	Data Processing	83
Horizon Healthcare	Administrative Consultant	9,103
Personnel Planners	Unemployment Consultant	1,362
Joint Commission	Accreditation	2,592
See Attached Schedule	Legal	40,484
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 507,210

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 62,616
Unemployment Compensation Insurance	34,347
FICA Taxes	291,695
Employee Health Insurance	186,053
Employee Meals	53,801
Illinois Municipal Retirement Fund (IMRF)*	
Head Tax	6,886
Employee Pension	34,600
Miscellaneous Employee Benefits	3,982
Holiday Expense	7,215
TOTAL (agree to Schedule V, line 22, col.8)	$ 681,195

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 100
Advertising: Employee Recruitment	452
Health Care Worker Background Check	2,218
(Indicate # of checks performed)	
Advertising	2,917
Associated Dues	7,293
Public Relations	24,582
Dues and Subscriptions	787
Licenses	1,306
Alloc. Itex Mgmt /A.K. Care/CarePath	11,639
Less: Public Relations Expense	(24,582)
Non-allowable advertising	(2,917)
Yellow page advertising	
TOTAL (agree to Sch. V, line 20, col. 8)	$ 23,795

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	5,277
Alloc. CarePath	38
Alloc. Itex Mgmt. / A.K. Care	1,558
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,873

**See instructions.

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? _____
If YES, give association name and amount. **ICLTC = $10,962**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **11,956** Line **10-02**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **98,550**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **53,801** Has any meal income been offset against related costs? **No** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **100% ln 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees